Adriana Vanbianchi, Paramedic, RN, BSN
Methow Valley School District, 18 Twin Lakes Road, Winthrop, WA 98862
Elementary phone (509) 996-2186
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Request for Administration of Intranasal Anti-Seizure Medication for MVSD Student
Name:_____Birthdate: _____

• The student's Washington State licensed health care prescriber must complete and sign Section I of this form prior to the child starting school each year.

• Parent/guardian must complete and sign Section II of this form prior to the child starting school each year.

• This completed form must be on file in the student's health record before prescription medication will be administered by school personnel.

I. Prescriber's Section This is to certify that the student named above is under my care for a seizure disorder and may need to have emergency Intranasal medication administered by staff of the Methow Valley School District. *Prescriber, please note: in Washington State, IM or rectal administration of medication cannot be performed by school staff. Nasal administration of medication is allowed with a pre-dosed medication (such as valtoco) being the most safe option to avoid medication administration error. A prior authorization is frequently required by insurance companies who need an explanation why rectal or IM antiseizure medication is not an option in Washington State public schools.*

Name of Anti-Siezure Medication_____

Please indicate when Intranasal medication is to be administered:_____
_____

Adverse reactions that should be reported to the prescriber:
_____
_____

Storage instructions:
_____
_____

Other special instructions:
_____
_____

I understand that 911 will be called if this Intranasal Medication is given at the School .

Prescriber's signature/title: _____
Date:_____

Prescriber (printed): _____

Phone: _____Fax:_____

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II. Parent/Guardian's Section I hereby request and give my permission for school district licensed nursing staff to administer the prescribed Intranasal medication to my child in accordance with the specific written instructions of our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested. I am responsible for the delivery of the Intranasal emergency medication to the school and will notify the school immediately if the doctor changes the dosage or we change our medical provider or the need for Intranasal emergency anti-seizure medication is terminated. I understand 911 will be called when Intranasal medication is given.

Parent/Guardian signature: _____

Date: _____

Home address: _____

Phone: _____